DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/29/13

PRINTED: 08/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445264	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUGHLIN HEALTH CARE CENTER	801 E MCKEE ST GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification and complaint investigation #32026 were completed on August 15, 2013, at Laughlin Health Care Center. No deficiencies were cited related to complaint investigation #32026 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	**Laughlin Healthcare Center acknowledges that during the Annual Recertification Survey and Complaint Investigation #32026, completed on August 15, 2013, no deficiencies were cited related to the complaint investigation #32026 under 42 CFR Part 483, Requirements for Long Term Care Facilities.**	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	**483.10(e), 483.75(l)(4) F 164 PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS** **REQUIREMENT:** The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage Continue to page 2 of 19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

R.N.A. Nursing Home Administrator 8/27/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain confidentiality of medical information for one resident (#4) of thirty residents reviewed. The findings included: Resident #4 was admitted to the facility on June 17, 2010, with diagnoses including Diabetes Mellitus, Alzheimer's Disease, Chronic Airway Obstruction, Urinary Tract Infection, Depression, and Chronic Pain. Observation during a staff interview on August 13, 2013, at 3:00 p.m., in the east wing dining area revealed Licensed Practical Nurse (LPN #2) seated in the Assistant Director of Nursing's (ADON) Office with the ADON. Continued observation revealed the ADON and LPN #2 discussed the medical history and diagnoses of resident #4 as they reviewed the medical record. Continued observation revealed a resident seated in a wheelchair behind LPN #2 and the ADON in the ADON office. Continued observation revealed the resident peered over the shoulders of LPN #2 and the ADON and viewed the open chart as the ADON and LPN #2 discussed the clinical status of resident #4. Interview with LPN #2 on August 13, 2013, at 3:10 p.m., in the east wing dining room confirmed the facility had failed to protect confidentiality of the medical record for resident #4.	F 164	Continued from page 1 of 19 methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. **POC:** 1. LPN was provided in-service education on 8/27/13 regarding maintaining confidentiality of Medical Records. 2. All nursing staff will receive in-service education on providing patient confidentiality. This will be completed by 9/06/13. 3. All nursing staff will receive an in-service education regarding the facility confidentiality policy, with emphasis on confidentiality of individual resident records. 4. The DON, ADON and nurse managers will monitor for compliance during daily observation and follow-up findings will be addressed in the Monthly QA Meetings. **September 6, 2013**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	**483.15(a) F 241 DIGNITY AND RESPECT OF INDIVIDUALITY** Continue to page 3 of 19	

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F 241	Continued From page 2 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote an environment to maintain and enhance dignity for six of thirty-four residents observed. The findings included: Observation on August 12, 2013, at 12:30 p.m., at the west wing nurse's station revealed five residents (#36, #86, #35, #42, #66) sitting in front of the nurse's station in the hallway eating lunch. Observation on August 13, 2013, at 8:15 a.m., at the west wing nurse's station revealed five residents (#36, #86, #35, #42, #66) sitting in the hallway in front of the nurse's station eating breakfast. Observation on August 13, 2013, at 8:30 a.m., at the east wing nurse's station revealed one resident (#85) in the hallway in front of the nurse's station eating breakfast. Interview on August 15, 2013, at 10:30 a.m., at the east wing nurse's station with Licensed Practical Nurse (LPN #1) revealed the residents were in the hallway because there was not enough room in the small dining rooms. Continued interview with LPN #1 confirmed the facility had failed to maintain the resident's	F 241	Continued from page 2 of 19 **REQUIREMENT:** The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. POC: 1. All residents that sit in the hallway in front of the nursing stations for dining have been interviewed and all but # 86 insist that they remain in the hallway sitting in front of the nursing station for dining, and this is resident right and resident choice. Resident #86 has been moved into the West Wing small dining room for dining. 2. New admissions will be encouraged to eat in main dining room unless contra-indicated by safety issues. If safety issue is a concern, the patient will be placed in small dining room and encouraged to have all meals in that area. 3. The area in the hallways in front of the nursing stations will now be designated as an extended dining area, with a sign placed outside the small dining rooms designating the area as an extension of the dining room. Appropriate tables will be added to the area during dining. 4. The DON, ADON, Wing Managers and/or designees will assess residents on admission for safest dining area and will be placed appropriately. Current residents will be encouraged to eat in small dining areas but their choices and rights will be honored. Current residents in dining area have been care Continued to page 4 of 19	

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F 241	Continued From page 3 dignity.	F 241	Continued from page 3 of 19 planned according to their choice.	
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of Resident Council Minutes and interview, the facility failed to address grievances made during Resident Council meetings for six of the last seven months. The findings included: Review of the Resident Council Minutes dated January 24, 2013, revealed "...Nursing: There were two complaints this month about night shift CNAs (Certified Nursing Assistants)...not answering the call lights in a timely fashion... (residents) were waiting a long time after answering the call lights before (CNA's were) coming to take care of them..." Review of Resident Council Minutes dated February 24,2013, revealed "...Nursing...Some felt call lights were not getting answered as soon as they need to be by staff...All complaints forwarded to appropriate departments. Will follow up on concerns..." Review of Resident Council Minutes dated March	F 244	September 6, 2013 **483.15(c)(6) F 244 LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION** **REQUIREMENT:** When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. **POC:** 1. The facility will conduct initial and periodic checks of each residents call light for correct placement. The concerns of the residents from the resident council meeting will be typed and sent to the Department Heads within 24 hours of the resident council meeting and the concerns will be investigated and addressed by the Department Heads in a meeting within a week. The results of the investigations and the interventions implemented will be brought before the resident council in the next scheduled meeting. 2. All resident grievances will be treated with respect and an investigation of each grievance will be conducted and appropriate interventions will be implemented. 3. The QA Nurse will be conducting periodic assessment of call light placement, and if deficient practice does Continue to page 5 of 19	

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F 244	Continued From page 4 28, 2013, revealed "...Nursing: 1. Couple of residents said they have not been able to reach their call light in their room...Council members request this be discussed with the Director of Nursing..." Review of Resident Council Minutes for May 23, 2013, June 27, 2013, and July 25, 2013, revealed grievances related to the call lights not being answered in a timely manner. Interview with the Resident Council President on August 14, 2013, at 1:10 p.m., in the resident's room revealed there had not been any resolution of the resident's concerns. Continued interview confirmed no follow up had occurred. Interview with the Activity Director in the Activity office on August 14, 2013, at 1:50 p.m., revealed when grievances are identified during the council meeting a copy of the council minutes are emailed to all department heads. Continued interview with the Activity Director confirmed there had not been any follow up completed for the grievances by the Activity Director. Continued interview with the Activity Director revealed the Administrator also received copies of the minutes and was aware of the grievances. Interview with the Administrator on August 14, 2013, at 2:10 p.m., in the Administrator's office revealed the Resident Council minutes were reviewed at Department Head meetings. Continued interview revealed no tracking or follow up had been completed with the Resident council. When asked if there had been any meetings concerning the grievances documented at the Resident Council meeting since January 2013 the Administrator stated "no." The Administrator	F 244	Continued from page 4 of 19 occur, an in-service will be given to all facility staff. 4. This process will be monitored by the DON, ADON, Wing Managers, Activity Director, Administrator, Social Services and Resident Council members to assure that the grievances are being addressed. Monthly resident council meetings will continue to be monitored for all grievances expressed. September 6, 2013	

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F 244	Continued From page 5 confirmed the facility had failed to act upon the Resident Council grievances.	F 244		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain a homelike atmosphere during dining activities in one of three dining areas observed. The findings included: Observation on August 12, 2013, from 12:20 to 12:50 p.m., in the main dining hall revealed facility staff members placed clothing protectors on twenty of twenty-two residents without asking the residents if they preferred to use clothing protectors during the meal. Observation on August 13, 2013, from 8:30 a.m. to 8:42 a.m., in the main dining hall revealed facility staff members placed clothing protectors on eight of eight observed residents without asking the residents if they preferred to use clothing protectors during the meal. Observation on August 14, 2013, at 5:00 p.m., in the main dining hall revealed clothing protectors in use for twenty-three of twenty-three residents.	F 252	**483.15(h)(1) F 252** **SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT** **REQUIREMENT:** The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. **POC:** 1. The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity. The CNAs will ask the residents in the main dining room if they prefer to use clothing protectors during meals. 2. Other residents in the facility, other than the main dining area will be asked if they prefer to use clothing protectors during meals. 3. An in-service will be given to all nursing staff on the importance of asking residents before placing clothing protectors. This will be done in respect of resident's dignity. 4. This process will be monitored by DON, ADON, Wing Managers, and Activity Director to assure respect of resident's dignity. Periodic in-service will be given to ensure this practice continues. **September 6, 2013**	

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F 252	Continued From page 6 Review of facility policy, Feeding the Resident, revised March 2005 revealed "...use special articles as indicated..." Interview with the Director of Nursing (DON) on August 15, 2013, at 3:20 p.m., in the DON's office confirmed the staff had failed to ask each resident's permission prior to using the clothing protectors prior to the application of the clothing protectors. Continued interview confirmed the facility had failed to maintain a homelike atmosphere in the main dining area.	F 252		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	483.20(b)(1) F 272 COMPREHENSIVE ASSESSMENTS REQUIREMENT: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Continue to page 8 of 19	

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F 272	Continued From page 7 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess for medication side effects for one (#30) of thirty residents reviewed. The findings included: Resident #30 was admitted to the facility on June 29, 2013, with diagnoses including Fractured Neck of Femur (hip fracture) and Diabetes Mellitus. Medical record review of the Physician's orders revealed on July 31, 2013, the Physician stopped the injectable anticoagulation (blood thinner) medication. Continued review of the Physician's order dated August 2, 2013, revealed the Physician ordered Aspirin 325 milligrams daily (used as a blood thinner). Review of the care plan dated July 12, 2013,	F 272	Continued from page 7 of 19 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimun Data Set (MDS); and Documentation of participation in assessment. **POC:** 1. A head to toe assessment was completed on resident #30 on August 29, 2013, with no other bruising noted. 2. All current residents on anticoagulation medications have been assessed for signs and symptons of bleeding. 3. An in-service to all nursing staff will be conducted on side effects of anticoagulation. A weekly skin assessment will be conducted by an RN on all residents. Current residents on anticoagulation, including aspirin, have had their current care plans updated to include side-effect of medication. 4. The DON, ADON, Wing Managers and/or designees will monitor assessments for residents with anticoagulation therapy for accuracy and compliance on new admissions and quarterly in coordination with MDS schedule. September 6, 2013	

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F 272	Continued From page 8 revealed "...Observe for signs of active bleeding, purpura (bruises in the deep tissues), ecchymotic areas (small blue or purplish bruises), hematoma, blood in urine, blood in stools, hemoptysis (blood in the sputum), elevated temp, pain in joints, abdominal pain, epistaxis (nose bleed)..." Observation on August 12, 2013, at 3:00 p.m., in the resident's room revealed a nickel sized bruise on the left hand and several penny sized bruises on the left arm. Interview with resident #30 revealed the resident thought the bruises were a result of bumping the hand/arm and due to the medications the resident received. Observation on August 14, 2013, at 3:15 p.m., near resident #30's room revealed a new bruise on the resident's right hand approximately 2 inches by 2 ½ inches. Resident #30 stated "bumped my hand this morning." Review of the Nurse's Notes dated on August 1, 2013 through August 13, 2013, revealed no documentation of the resident's bruising. Interview on August 15, 2013, at 11:00 a.m., near the east nurse's desk with Licensed Practical Nurse (LPN #1) revealed LPN #1 was the resident's Charge Nurse for that day and was unaware the resident had bruises on the hand and arm. Continued interview confirmed the bruises should have been assessed due to the resident being on Aspirin.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	**483.20(d), 483.20(k)(1) F 279 DEVELOP COMPREHENSIVE CARE PLANS** **REQUIREMENT:** A facility must use the Continue to page 10 of 19	

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F 279	Continued From page 9 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan of two (#6, #108) of thirty residents reviewed. The findings included: Resident #6 was admitted to the facility on July 26, 2013, with diagnoses including Surgical Removal of Malignant Neoplasm of the Mandible, Weakness, and Placement of Nasal Gastric Tube (NG) (for food/fluids). Review of the Hospital Patient Summary dated July 26, 2013, revealed resident #6 had Physician's orders to keep the surgical sites clean and dry, rinse mouth with warm salt water, to be NPO (nothing by mouth) and fed via NG tube,	F 279	Continued from page 9 of 19 results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). POC: 1. The care plan of Resident #6 has been updated to reflect mouth care as ordered by MD. The care plan of Resident #108 has been updated to reflect range of motion to affected arm per restorative nursing program. 2. Residents with contractures will have their care plan assessed for appropriate interventions related to contractures. Resident #6 was receiving mouth care as ordered by MD but intervention was failed to be placed on care plan upon admission, but the care plan is now updated to reflect mouth care. Continue to page 11 of 19	

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PRINTED: 08/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445264	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUGHLIN HEALTH CARE CENTER	801 E MCKEE ST GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10 until swallow study. Review of the Care Plan dated July 26, 2013, revealed no problems or approaches to provide care for the resident's healing mouth. Observation on August 12, 2013, at 10:30 a.m., in the resident's room revealed the resident sitting in a wheelchair with a NG tube in place. Observation on August 13, 2013, at 9:00 a.m., in the resident's room revealed the resident sitting in a wheelchair with the NG tube no longer present and fluids being administered via Intravenous (IV). Interview on August 14, 2013, at 9:40 a.m., with the East Unit Manager confirmed the resident's condition "was very important" and not addressed on the Care Plan. Resident #108 was admitted to the facility on January 10, 2012, with diagnoses including Dementia, Seizure Disorder, and Hemiplegia (loss of function on one side of the body). Record review of the Physician's orders for August 2013 revealed "...Restorative Nursing Program 3X wk (week)..." Review of the Care Plan dated September 19, 2012, revealed no interventions for the right arm contracture. Interview on August 14, 2013, at 4:20 p.m., with the East Unit Manager at the east nurse's desk confirmed the care plan did not include any interventions to address the arm contracture.	F 279	Continued from page 10 of 19 3. Upon admission, residents will be assessed for contractures and appropriate interventions placed on care plan. All residents with alternate feeding methods will be care planned for appropriate mouth care upon admission and PRN. Current residents will be assessed quarterly according to MDS schedule. 4. The DON, ADON, Wing Managers and/or designee will monitor present alternate fed residents for mouth care and appropriate intervention for the next two weeks and then quarterly according to MDS schedule. Current residents with contractures will be placed in a restorative program and the process will be monitored by the DON, ADON, Wing Managers and /or designee. **September 13, 2013**	

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F 309 F 309 SS=D	Continued From page 11 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide care as directed by the care plan for one (#30) of thirty residents reviewed. The findings included: Resident #30 was admitted to the facility on June 29, 2013, with diagnoses including Fractured Neck of Femur (hip fracture) and Diabetes Mellitus. Review of the Care Plan dated July 12, 2013, revealed "...Observe for signs of active bleeding, purpura (bruises in the deep tissues), ecchymotic areas (small blue or purplish bruises), hematoma (bruises), blood in urine, blood in stools, hemoptysis (blood in the sputum), elevated temp, pain in joints, abdominal pain, epistaxis (nose bleed)..." Observation on August 12, 2013, at 3:00 p.m., in the resident's room revealed a nickel sized bruise on the left hand and several penny sized bruises on the left arm. Interview revealed the resident	F 309 F 309	**483.25 F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **REQUIREMENT:** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **POC:** 1. Resident #30 has been assessed for further signs and symptons of bleeding as indicated on comprehensive care plan. Complete skin assessment by Wing Manager revealed no other skin issues. 2. A weekly head to toe skin assessment will be conducted by RN and noted in resident's medical record. 3. An in-service will be given by QA Nurse to licensed nursing and CNA nursing regarding important potential side effects of anticoagulants. 4. The DON, ADON, Wing Managers and/or designees will conduct skin audits weekly for compliance. CNAs will inspect skin daily during routine care and report any problems to their charge nurse. **September 6, 2013**	

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F 309	Continued From page 12 thought the bruises were a result of bumping the hand/arm and due to the medications the resident received. Observation on August 14, 2013, at 3:15 p.m., near the resident's room revealed a new bruise on the resident's right hand, approximately 2 inches by 2½ inches. Resident #30 stated "bumped my hand this morning." Review of the Nurse's Notes dated from August 1, 2013 through August 13, 2013, revealed no documentation of the resident's bruising. Interview on August 15, 2013, at 11:00 a.m., near the east nurse's desk with Licensed Practical Nurse (LPN #1) revealed LPN #1 was the resident's Charge Nurse for that day and was unaware the resident had bruises on the hand and arm. Observation of the resident on August 15, 2013, at 1:30 p.m., near the courtyard door with the East Unit Manager revealed the Unit Manager was unaware of the resident's bruising on both hands and the left arm. Interview on August 15, 2013, at 1:40 p.m., at the east nurse's desk with the East Unit Manager confirmed the resident received Aspirin as an anticoagulant and the resident was not monitored for side effects of the medication.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	**483.25(h) F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **REQUIREMENT:** The facility must ensure that the resident environment remains as free Continue to page 14 of 19	

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F 323	Continued From page 13 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, observation, and interview, the facility failed to implement new interventions after two falls for one (#75) of thirty residents reviewed. The findings included: Resident #75 was admitted to the facility on June 22, 2012, with diagnoses including Dementia, Depression, Anxiety, History of Fall with Rib Fractures, and Glaucoma. Record review of a facility investigation dated August 8, 2013, revealed after hearing the alarm sound a Certified Nurse Assistant found the resident on the floor on the resident's knees trying to get into the bed (the resident had been in the w/c). Continued review revealed no injuries were found. Further review of the facility investigation revealed "...Additional comments and/or steps taken to prevent reoccurrence: Resident is A/O (alert and oriented). Educated to call for assistance..." Record review of a facility investigation dated August 10, 2013, revealed "...Resident observed sitting on mat on floor, states...was trying to reach the reacher and slid out, bed in low position...No injuries...Additional comments and/or steps taken to prevent reoccurrence: Resident encouraged to ask for assistance. Continue with mat for	F 323	Continued from page 13 of 19 of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **POC:** 1. Resident #75 has been moved to a room closer to the nursing station. Resident care plan has been reviewed and interventions revised. 2. Licensed nurses have been re-educated on the fall prevention program and assessing residents post-fall for possible new interventions and updating care plan. 3. The DON, ADON, Wing Managers and/or designees will complete random audits of resident falls with care plan interventions weekly for one month, then quarterly in accordance with MDS assessments. 4. The DON, ADON, Wing Managers and/or designees will present results in monthly QA meetings for revisions as needed. **September 6, 2013**	

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F 323	Continued From page 14 safety..." Review of the current Care Plan dated July 10, 2013, revealed approaches "...Bed and w/c alarm to alert staff of unassisted rising...is unaware of safety issues at times...Call light within reach. Instuct...to use...call light for staff assistance...Staff assist x1 for transfers, staff assist x1 for ambulation, walker for stability, Staff assist X1 for toileting. Continent of bowel...Bed in lowest position when...is in bed with bedside mat...Complete fall risk assessments routinely per facility protocal...Have...wear gripper socks when not wearing shoes to help prevent falls...Have...wear non-skid shoes when ambulating...Observe for decrease or loss of functional status...Observe for gait unsteadiness when ambulating...," Observation on August 14, 2013, at 9:30 a.m., in the resident's room revealed the resident lying in a low bed with the call light within reach and a mat beside the bed. Interview on August 15, 2013, at 10:15 a.m., at the east nurse's desk with the East Unit Manager confirmed no new interventions were put in place to prevent another fall after the August 8, 2013, and August 10, 2013, falls.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions .	F 371	**483.35(i) F 371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY** **REQUIREMENT:** The facility must- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. Continue to page 16 of 19	

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F 371	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store plates in a sanitary manner, discard out of date milk, and maintain the ice machine in a sanitary manner. The findings included: Observation with the Assistant Dietary Manager during the initial tour on August 12, 2013, at 9:45 a.m., revealed two wet divided plates and one wet regular plate in the plate warmer; the reach in cooler had a quart size container of buttermilk, ½ full with a use by date of August 6, 2013, dated as opened on August 11, 2013; and the ice machine had a pink colored substance on the ice slide. Interview with the Assistant Dietary Manager during the observations confirmed dishes need to be dry before storage to prevent contamination, the milk was out of date and should not be served to the residents, and the pink substance on the ice slide was unsanitary.	F 371	Continued from page 15 of 19 **POC:** 1. No residents were found to be affected by this citation. 2. The wet items were immediately removed, the buttermilk was disposed of immediately and the ice machine was emptied, the ice disposed of and the ice machine was cleaned and sanitized with bleach, so no residents have the potential to be affected by this citation. 3. The dish machine was repaired on August 13, 2013, and if any wet items are found, they will be immediately removed and re-washed and sanitized and air dried. The Dietary staff was in-serviced on how to read expiration dates and the proper cleaning of all equipment. Items are checked by Dietary Supervisors prior to each meal for use by dates. The ice machine will be emptied and cleaned twice a month. A bacteria growth prevention system in ice machines will be installed. Dietary Supervisors will check the above items. 4. The Dietary Supervisors will monitor to assure plates are stored in a sanitary manner, out of date items are discarded and the ice machine is maintained in a sanitary manner. **September 6, 2013**	
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 372	**483.35(i)(3) F 372 DISPOSE GARBAGE & REFUSE PROPERLY** **REQUIREMENT:** The facility must dispose of garbage and refuse properly. **POC:** 1. No residents were affected in this Continue to page 17 of 19	

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F 372	Continued From page 16 Based on observation and interview, the facility failed to provide intact dumpsters to dispose of garbage appropriately for two of two dumpsters. The findings included: Observation with the Assistant Dietary Manager on August 13, 2013, at 4:30 p.m., near the loading dock revealed one dumpster had white liquid dripping from two areas on the bottom of the dumpster to the ground. Continued observation revealed the second dumpster had a gap in the seam on the right side bottom with an open area approximately 2 inches by 5 inches with trash visable. Interview with the Assistant Dietary Manager confirmed both dumpsters were not intact for appropriate disposal of garbage.	F 372	Continued from page 16 of 19 citation. 2. No residents have the potential to be affected by this citation. 3. A Welding Co. was contacted on August 27, 2013 by the Maintenance Director to repair the current dumpsters. Capital Budget request has been made for a new Trash Compactor and will be purchased when funding is approved and available. All staff have been reminded and in-serviced, and signs made to be posted to empty all containers prior to placing in the trash cans. 4. The facility Maintenance Technician and Dietary Supervisors will monitor for proper integrity of dumpsters for appropriate disposal of garbage.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	September 13, 2013 **483.65 F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS** **REQUIREMENT:** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and Continue to page 18 of 19	

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F 441	Continued From page 17 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3).The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide hand sanitation while assisting residents with meals in two of four dining rooms. The findings included: Observation on August 12, 2013, at 12:00 p.m., in the restorative dining room revealed Restorative Aide (RA #1) was assisting one resident with holding the spoon and fork. Continued observation revealed occasionally RA #1 used the spoon and fork to feed the resident and wipe the resident's mouth with a napkin. Continued observation revealed RA #1 removed the food soiled lid of a sippy cup for another resident, rinsed out the cup, poured ice tea into the sippy cup, replaced the lid, and handed the sippy cup to the other resident. Observation revealed without	F 441	Continued from page 17 of 19 corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. **POC:** 1. Restorative aids and CNAs will be in-services on correct procedure for hand washing when assisting different residents. 2. The DON, ADON, Wing Managers and/or designees will monitor each dining area for other residents that could be affected. 3. An in-service will be conducted for all nursing staff on proper procedure for hand washing when assisting more than one resident. CNAs and restorative aids will be provided small bottles of hand Continue to page 19 of 19	

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F 441	Continued From page 18 sanitizing the hands continued to assist/feed the first resident. Interview on August 15, 2013, at 10:00 a.m., with RA #1 outside of the conference room confirmed the hands were not sanitized after handling the soiled sippy cup of another resident and continuing to feed the first resident. Observation of the west wing dining room on August 13, 2013, at 12:20 p.m., revealed Certified Nursing Assistant (CNA #2) feeding two residents at table number three. Observation revealed CNA #2 put a spoonful of food in a resident's mouth, wiped the resident's mouth with a napkin, then turn and repeat the process with another resident. Continued observation revealed CNA #2 alternated between the two residents without sanitizing hands between contact of the residents. Interview with CNA #2 at the time of the occurrence confirmed the hands were not santized between residents.	F 441	Continued from page 18 of 19 sanitizer for cleaning hands when assisting more than one resident. 4. The DON, ADON, Wing Managers and/or designees will monitor process each meal for one week and then monthly for six months and present findings to the QA Committee for further recommendations if deficit found. September 6, 2013	